Home Health
High Impact Practices

Fraser Health Board
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Home is BEST – Fraser Health

Canadian Home Care Association
~ High Impact Practices

HOME IS BEST: Developing an Integrated Primary and Home & Community Care System

LPNs in Home Health
Prociuk & Meadows, Integrating Licensed Practical Nurses Into Home Care Nursing: One Health Authority’s Journey, Home Healthcare Nurse, vol 30, no 5. May 2012
What is Home Health?
Congestion across system

Fraser Health Population to Grow Another 20% by 2020

~400 patients daily waiting for a different level of care

200 people admitted in ED

Seniors cohort 65 yrs+ to grow by 45% by 2020
Congestion within Home Health

- Our “beds” are our people – finite care hours
- 650 referrals to Home Health a week from acute care
- Over 14,000 clients receiving service daily
- 34,000 referrals annually from acute care
- Our people - health human resource challenges
Capacity in Home Health

Home First - 75 client diversions in ED at period 6

~90 referrals from acute to Home Health daily

Home Health PREVENTS Admissions

Home Health FOSTERS Discharges

215 complex clients “pulled” to home YTD

Every 90 day period:
- 3 in 4 long term clients do NOT visit ED
- 5 in 6 do NOT go to hospital
Construction

Work smarter – fundamental redesign & improved processes

1. Home is Best - Integrate H&CC, Acute & Primary Care
2. Expand community support services
3. Telephone outreach

Our Beds = Our People
Adopt a collaborative practice approach – RNs & LPNs; Rehab Assistants, Client Services Assistants
Home is Best

*Fraser Health is pioneering this philosophy in BC, across the system*

- Longer hospital stays = decreased mobility, confusion, risk of infection
- Home the best place to recover and manage conditions, with appropriate supports
- Most seniors *want* to live at home
- Residential Care, last resort
Home is Best so Home First

*Acute Care teams are educated to consider ‘home’ as the first option instead of residential care.*

- Patients to try living at home with supports, if appropriate (<5% failure)
- Case Manager monitors to ensure the patient is managing safely at home
- If care needs can no longer be safely met, patients are assessed for assisted living or residential care.
Integrated Health Networks

Home Health / GP Partnerships

- Case manager single contact for GP practices
- Support LTC patients (high ED and hospital users)
- Comprehensive, proactive care management with GP
- Nurse surveillance by phone

Closes the loop with upstream benefits: Avoidance of future emergency department visits and hospitalization
Our People - Diversification

LPNs Collaborating with RNs in Home Care Nursing – Clinic & Community – A Progressive Journey
Increasing need for Consultation & Collaboration with RN

Reference: PEI based on College of Nurses of Ontario

Client Continuum

Stable health condition, predictable health outcomes, less complexity, low risk for negative outcomes

Unstable health conditions, unpredictable health outcomes, high complexity, high risk for negative outcomes

Independent LPN Practice

Increasing need for Consultation & Collaboration with RN

Independent RN Practice

Or Joint RN & LPN
Questions?